CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
(As Amended at ARRS, April 12, 2018)

907 KAR 17:020. Managed care organization service and service coverage requirements and policies.

RELATES TO: KRS 194A.025(3), Chapters 202A, 645, 42 U.S.C. 1396n(c), 42 C.F.R. 422.113(c), 431.51(a)(4), 431.52, Part 438, 447.500-447.522, 42 U.S.C. 1396b(m)(2)(A)(xiii), 1396d(r), 1396u-2(b)(2)(A)(i), (ii)***[,]***

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization service and service coverage requirements and policies.

Section 1.[~~MCO Service Areas. An MCO's service areas shall be as established in the MCO Service Areas.~~

~~Section 2.~~] Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision of a covered health service:

(a) That[~~Which~~] is established in Title 907 of the Kentucky Administrative Regulations;

(b) That[~~Which~~] shall be in the amount, duration, and scope that the services are covered for recipients pursuant to the department's administrative regulations located in Title 907 of the Kentucky Administrative Regulations; and

(c) Beginning on the date of enrollment of a recipient into the MCO.

(2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an MCO shall be responsible for the cost of a non-nursing facility covered service provided to an enrollee during the first thirty (30) days of a nursing facility admission in accordance with this administrative regulation.

(3) An MCO shall not be responsible for the provision or costs of the following:

(a) A service provided to a recipient in an intermediate care facility for individuals with an intellectual disability;

(b) A service provided to a recipient in a 1915(c) home and community based waiver program;

(c) A hospice service provided to a recipient in an institution;

(d) A nonemergency medical transportation service provided in accordance with 907 KAR 3:066;

(e) Except as established in Section 5[~~6~~] of this administration regulation, a school-based health service;

(f) A service not covered by the Kentucky Medicaid Program;

(g) A health access nurturing development service pursuant to 907 KAR 3:140;

(h) An early intervention program service pursuant to 907 KAR 1:720; or

(i) A nursing facility service for an enrollee during the first thirty (30) days of a nursing facility admission.

(4) The following covered services provided by an MCO shall be accessible to an enrollee without a referral from the enrollee's primary care provider:

(a) A primary care vision service;

(b) A primary dental or oral surgery service;

(c) An evaluation by an orthodontist or a prosthodontist;

(d) A service provided by a women's health specialist;

(e) A family planning service;

(f) An emergency service;

(g) Maternity care for an enrollee under age eighteen (18);

(h) An immunization for an enrollee under twenty-one (21);

(i) A screening, evaluation, or treatment service for a sexually transmitted disease or tuberculosis;

(j) Testing for HIV, HIV-related condition, or other communicable disease;**[~~and~~]**

(k) A chiropractic service**;**

(l) A behavioral health service; and

(m) A substance use disorder service.

(5) An MCO shall:

(a) Not require the use of a network provider for a family planning service;

(b) In accordance with 42 C.F.R. 431.51(a)(4)[~~(b)~~], reimburse for a family planning service provided within or outside of the MCO's provider network;

(c) Cover an emergency service:

1. In accordance with 42 U.S.C. 1396u-2(b)(2)(A)(i);

2. Provided within or outside of the MCO's provider network; and[~~or~~]

3. If provided out-of-state, in accordance with 42 C.F.R. 431.52;

(d) Comply with 42 U.S.C. 1396u-2(b)(2)(A)(ii); and

(e) Be responsible for the provision and reimbursement of a covered service as described in this section beginning on or after the beginning date of enrollment of a recipient with an MCO as established in 907 KAR 17:010.

(6)(a) If an enrollee is receiving a medically necessary covered service the day before enrollment with an MCO, the MCO shall be responsible for the reimbursement of continuation of the medically necessary covered service without prior approval and without regard to whether services are provided within or outside the MCO's network until the MCO can reasonably transfer the enrollee to a network provider.

(b) An MCO shall comply with paragraph (a) of this subsection without impeding service delivery or jeopardizing the enrollee's health.

(7) To determine if a service is medically necessary and clinically appropriate, the MCO shall:

(a) Comply with 907 KAR 3:130; and

(b) Make utilization decisions **as follows:**

1. *Until the commissioner of the Department of Insurance issues a final order pursuant to 2018 Ky. Act ch. 69, Section 10(1)(b)2., in accordance with nationally recognized criteria as approved by the department; and*

2. Once the commissioner of the Department of Insurance issues a final order pursuant to 2018 Ky. Acts ch. 69, Section 10(1)(b)2., by complying with 2018 Ky. Acts ch. 69, Section 5[~~Except as provided in subparagraphs 2. and 3. of this paragraph, by using Intergual, unless Intergual criteria does not specifically address a particular service or a particular population in which case the MCO shall submit its proposed medical necessity criteria for the particular service or population to the department for approval;~~

2. For substance use, by using the American Society of Addiction Medicine (ASAM);

and

3. For behavioral health services not covered by Interqual, by using the following standardized tools:

a. For adults, the Level of Care Utilization System (LOCUS);

b. For children, the Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); and

c. For young children, the Early Childhood Service Intensity Instrument (ECSII)]**[using Interqual, unless otherwise negotiated in the MCO contract]**.

Section 2[~~3~~]. Early and Periodic Screening, Diagnosis[~~Diagnostic~~], and Treatment (EPSDT) Services. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years with EPSDT services in compliance with:

(a) 907 KAR 11:034; and

(b) 42 U.S.C. 1396d(r).

(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 3[4]. Emergency Care, Urgent Care, and Post-stabilization Care. (1) An MCO shall provide to an enrollee:

(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and

(b) Urgent care within forty-eight (48) hours.

(2) Post-stabilization services shall be provided and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

(3)**(a)** Prior authorization shall not be required for a physical emergency service or a behavioral health emergency service.

(b) In order to be covered, an emergency service shall be:

1. Medically necessary; **and**

2.**[~~Authorized after being provided if the service was not prior authorized; and~~**

~~3.~~] Covered in accordance with Section 1(5)(c) of this administrative regulation.

Section 4[~~5~~]. Maternity Care. An MCO shall:

(1) Have procedures to assure:

(a) Prompt initiation of prenatal care; or

(b) Continuation of prenatal care without interruption for a woman who is pregnant at the time of enrollment;

(2) Provide maternity care that includes:

(a) Prenatal;

(b) Delivery;

(c) Postpartum care; and

(d) Care for a condition that complicates a pregnancy; and

(3) Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 5[~~6~~]. Pediatric Interface. (1) An MCO shall:

(a) Have procedures to coordinate care for a child receiving a school-based health service or an early intervention service; and

(b) Monitor the continuity and coordination of care for the child receiving a service referenced in paragraph (a) of this subsection as part of its quality assessment and performance improvement (QAPI) program[~~established in 907 KAR 17:025~~].

(2) Except when a child's course of treatment is interrupted by a school break, after-school

hours, or summer break, an MCO shall not be responsible for a service referenced in subsection (1)(a) of this section.

(3) A school-based health service provided by a school district shall not be covered by an MCO.

(4) A school-based health service provided by a local health department shall be covered by an MCO.

Section 6.[~~7. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll at least one (1) provider in its network who has the capacity to perform a forensic pediatric sexual abuse examination.~~

~~(2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee at the request of the DCBS.~~

~~Section 8.~~] Lock-in Program. (1) An MCO shall have a program to control utilization of:

(a) Drugs and other pharmacy benefits; and

(b) Non-emergency care provided in an emergency setting.

(2)(a) The program referenced in subsection (1) of this section shall be approved by the department.

(b) An MCO shall not be required to use the criteria established in 907 KAR 1:677 for placing an enrollee in the MCO's lock-in program if:

1. The MCO provides notice to the enrollee, in accordance with the adverse action notice requirements established in 907 KAR 17:010, of being placed in the MCO's lock-in program; and

2. The enrollee is granted the opportunity to appeal being placed in a lock-in program in accordance with the:

a. MCO internal appeal process requirements established in 907 KAR 17:010; and

b. The department's state fair hearing requirements established in 907 KAR 17:010.

Section 7[~~9~~]. Pharmacy Benefit Program. (1) The pharmacy benefit program shall be in compliance with the applicable federal and state law, including 42 U.S.C. 1396b(m)(2)(A)(xiii)**[~~,~~]** and 42 C.F.R. 447.500 through 447.522**[~~, and the negotiated terms of the contract between the MCO and the department~~]**.

(2)[~~An MCO shall:~~

~~(a) Have a pharmacy benefit program that shall have:~~

~~1. A point-of-sale claims processing service;~~

~~2. Prospective drug utilization review;~~

~~3. An accounts receivable process;~~

~~4. Retrospective utilization review services;~~

~~5. Formulary and non-formulary drugs;~~

~~6. A prior authorization process for drugs;~~

~~7. Pharmacy provider relations;~~

~~8. A toll-free call center that shall respond to a pharmacy or a physician prescriber twenty-four (24) hours a day, seven (7) days a week; and~~

~~9. A seamless interface with the department's management information system;~~

~~(b) Maintain a preferred drug list (PDL);~~

~~(c) Provide the following to an enrollee or a provider:~~

~~1. PDL information; and~~

~~2. Pharmacy cost sharing information; and~~

~~(d) Have a Pharmacy and Therapeutics Committee (P&T Committee), which shall:~~

~~1. Meet periodically throughout the calendar year as necessary; and~~

~~2. Make recommendations to the MCO for changes to the drug formulary.~~

~~(2)(a) The department shall comply with the drug rebate collection requirement established in 42 U.S.C. 1396b(m)(2)(A)(xiii).~~

~~(b) An MCO shall:~~

~~1. Cooperate with the department in complying with 42 U.S.C. 1396b(m)(2)(A)(xiii);~~

~~2. Assist the department in resolving a drug rebate dispute with a manufacturer; and~~

~~3. Be responsible for drug rebate administration in a non-pharmacy setting.~~

~~(3) An MCO's P&T committee shall meet and make recommendations to the MCO for changes to the drug formulary.~~

~~(4)~~] If a prescription for an enrollee is for a non-preferred drug and the pharmacist cannot reach the enrollee's primary care provider or the MCO for approval and the pharmacist determines it necessary to provide the prescribed drug, the pharmacist shall:

(a) Provide a seventy-two (72) hour supply of the prescribed drug; or

(b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the request is for less than a seventy-two (72) hour supply.

(3)[~~(5)~~] Cost sharing imposed by an MCO shall not exceed the cost sharing limits established in 907 KAR 1:604.

Section 8.[~~10. MCO Interface with the Department Regarding Behavioral Health. An MCO shall:~~

~~(1) Meet with the department monthly to discuss:~~

~~(a) Serious mental illness and serious emotional disturbance operating definitions;~~

~~(b) Priority populations;~~

~~(c) Targeted case management and peer support provider certification training and processes;~~

~~(d) IMPACT Plus program operations;~~

~~(e) Satisfaction survey requirements;~~

~~(f) Priority training topics;~~

~~(g) Behavioral health services hotline; or~~

~~(h) Behavioral health crisis services;~~

~~(2) Coordinate:~~

~~(a) An IMPACT Plus covered service provided to an enrollee in accordance with 907 KAR 3:030;~~

~~(b) With the department:~~

~~1. An enrollee education process for:~~

~~a. Individuals with a serious mental illness; and~~

~~b. Children or youth with a serious emotional disturbance; and~~

~~2. On establishing a collaborative agreement with a:~~

~~a. State-operated or stated-contracted psychiatric hospital; and~~

~~b. Facility that provides a service to an individual with a co-occurring behavioral health and developmental and intellectual disabilities; and~~

~~(c) With the department and community mental health centers a process for integrating a behavioral health service hotline; and~~

~~(3) Provide the department with proposed materials and protocols for the enrollee education referenced in subsection (2)(b) of this section.~~

~~Section 11.~~] Behavioral Health Services. (1) An MCO shall:

(a) Provide a medically necessary behavioral health service to an enrollee in accordance

with the access standards established in 907 KAR 17:015, Section 2;

(b) Use the DSM-IV multi-axial classification system to assess an enrollee for a behavioral service;

(c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week;

(d) Not operate one (1) hotline to handle both an emergency or crisis call and a routine enrollee call; and

(e) Not impose a maximum call duration limit.

(2) Staff of a hotline referenced in subsection (1)(c) of this section shall:

(a) Communicate in a culturally competent and linguistically accessible manner to an enrollee; and

(b) Include or have access to a qualified behavioral health professional to assess and triage a behavioral health emergency.

(3) A face-to-face emergency service shall be available:

(a) Twenty-four (24) hours a day; and

(b) Seven (7) days a week.

Section 9.[~~12. Coordination Between a Behavioral Health Provider and a Primary Care Provider. (1) An MCO shall:~~

~~(a) Require a PCP to have a screening and evaluation procedure for the detection and treatment of, or referral for, a known or suspected behavioral health problem or disorder;~~

~~(b) Provide training to a PCP in its network on:~~

~~1. Screening and evaluating a behavioral health disorder;~~

~~2. The MCO's referral process for a behavioral health service;~~

~~3. Coordination requirements for a behavioral health service; and~~

~~4. Quality of care standards;~~

~~(c) Have policies and procedures that shall be approved by the department regarding clinical coordination between a behavioral health service provider and a PCP;~~

~~(d) Establish guidelines and procedures to ensure accessibility, availability, referral, and triage to physical and behavioral health care;~~

~~(e) Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;~~

~~(f) Identify a method to evaluate continuity and coordination of care; and~~

~~(g) Include the monitoring and evaluation of the MCO's compliance with the requirements established in paragraphs (a) to (f) of this subsection in the MCO's quality improvement plan.~~

~~(2) With consent from an enrollee or the enrollee's legal guardian, an MCO shall require a behavioral health service provider to:~~

~~(a) Refer an enrollee with a known or suspected and untreated physical health problem or disorder to their PCP for examination and treatment; and~~

~~(b) Send an initial and quarterly summary report of an enrollee's behavioral health status to the enrollee's PCP.~~

~~Section 13.~~] Court-Ordered Psychiatric Services. (1) An MCO shall:

(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) or over the age of sixty-five (65) who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapters 202A or 645;

(b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric service provided pursuant to a court-ordered commitment for an enrollee under the age of twenty-one (21) or over the age of sixty-five (65);

(c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and

(d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee's **district[~~region~~]** in accordance with 908 KAR **2:040[~~3:040~~]** and in accordance with the Olmstead decision.

(2) An MCO shall present a modification or termination of a service referenced in subsection (1)(b) of this section to the court with jurisdiction over the matter for determination.

(3)(a) An MCO behavioral health service provider shall:

1. Participate in a quarterly continuity of care meeting with a state-operated or state- contracted psychiatric hospital;

2. Assign a case manager prior to or on the date of discharge of an enrollee from a state-operated or state-contracted psychiatric hospital; and

3. Provide case management services to an enrollee with a severe mental illness and co-occurring developmental disability who is discharged from a:

a. State-operated or state-contracted psychiatric hospital; or

b. State-operated nursing facility for individuals with severe mental illness.

(b) A case manager and a behavioral health service provider shall participate in discharge planning to ensure compliance with the Olmstead decision.

Section 10[~~14~~]. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or

(2) Disapproves the policy. [~~Section 15. Incorporation by Reference. (1) "MCO Service Areas", November 2012 edition, is incorporated by reference.~~

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